FOUNDATIONONE® FOUNDATIONONE® Heme

Requisition Form

PLEASE FAX TO: +1 (617)-418-2290
EMAIL: Client.Services@FoundationMedicine.com

*Required Information

Time Sensitive – Please Expedite

☐ First Submission ☐ Second Submission ☐ Associated Requisition _____ ☐ Associated Study _____

Patient Information

Last Name*	First Name*	MI
Patient Medical Record #	Patient Date of Birth*	Patient Gender* ☐ M ☐ F
Street Address*		Apt. #
City*	Postal Code*	Country*
Patient Phone # (Primary)*		
Has the patient had any type of transplant?		

Ordering Physician Information

Office / Practice / Institution Name*		
Ordering Physician*		Account #
Street Address*		
City*	Postal Code*	Country*
Phone*	Fax*	
Email Address*		

Pathology Information

Hospital / Institution Name	Submitting Pathologist Name
Phone	Fax

Additional Physician to be Copied

Name	
Office / Practice / Facility Name	
Phone	Fax
Email Address	

Test Ordered* (CHECK ONE BOX)

☐ FoundationOne® (Optimized for solid tumors) ☐ FoundationOne® Heme (Optimized for hematologic malignancies and sarcomas)

Full gene lists are available at www.foundationone.com/genelist

☐ Authority given to Foundation Medicine to Change the Test Selected Above Based on Requisition Form / Pathology Information

Specimen Retrieval

Unless otherwise specified, Foundation Medicine will contact the pathology department indicated above to request your patient's specimen. Please indicate below if you would NOT prefer us to provide this service.

☐ DO NOT contact pathology regarding this case. I will arrange for the specimen to be shipped to Foundation Medicine.

Specimen Information

Diagnosis*	Stage*	Date of Collection*
Specimen Site*	Specimen I.D.*	ICD Code(s) Listed*

Billing Information* (Final Billing Will Include Local Value-Added Tax)

☐ Self-Pay – Credit Card	Name on Credit Card	Credit Card #	Exp. Date
	Cardholder Address		
☐ Self-Pay – Bank Transfer Please provide contact information for bank transfer	Payor Name	Payor Email Address	Payor Phone Number
☐ Clinics Institution will be billed after testing has been performed.			
☐ Other Please specifiy			

Please Attach the Following

☐ Copy of recent pathology / cytology reports

☐ Test results from all other Molecular Diagnostic Assays by FISH, IHC, or other genetic assays, e.g. ER, PR, HER2, EGFR, KRAS, etc.

☐ Front / back copy of insurance card

Comments, Remarks or Special Requests

Certificate of Medical Necessity / Consent

My signature constitutes a Certificate of Medical Necessity and certifies that I have explained to the patient the nature and purpose of the testing to be performed and have obtained informed consent, to the extent legally required, to permit Foundation Medicine to (a) perform the testing specified herein, (b) retain the test results for an indefinite period for internal quality assurance/operations purposes, (c) de-identify the test results and use or disclose such de-identified results for future unspecified research or other purposes, and (d) release the test results to the patient's third-party payer as needed for reimbursement purposes.

Physician Signature*

Ordering Physician Signature*	Date (MM/DD/YYYY)

For purposes of invoicing and money collection through Foundation Medicine's service partner F. Hoffmann-La Roche Ltd or any of its affiliated companies (together the "Roche Group"), Foundation Medicine will provide the patient's name, contact and billing information as necessary to the Roche Group. By signing this form, I am confirming that I have obtained patient consent to such data transfer. A list of all members of the Roche Group is available in the then current annual report which can be found under www.roche.com (http://www.roche.com/investors/reporting.htm).

FOUNDATION MEDICINE®

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